Statement #: 501083140

Account #:	Amount Due:	Amount Paid:	
2126469	0.00		☐Check ☐Discover ☐Visa ☐Master Card
Statement Date:	Date Due:	Credit Card Number:	Exp. Date:
07-02-2019	07-30-2019		
		Signature: X	

Make Checks Payable and Mail to:

Sheenah L Arenz
209 S WARREN ST

WATERTOWN, WI 53094

Fort Healthcare Inc
PO Box 249

Fort Atkinson, WI 53538

Please detach and return this portion with your payment.
Please indicate any name and/or address changes on this form.

	Account #:	Statement #:
	2126469	501083140

Provider of Service	Date of Service	Service Provided/ Account Activity	Charges, Payments, Adjustments	Insurance Pending	Patient Balance	*R
Patient Name: Sheenah L Arenz						
Date of Service: 01-15-2019 Financial#: 6971137						
Fort HealthCare Behavioral Health						
	01-15-2019	Psychiatric diagnostic evaluation, 90792 - MD w/med service	505.00	505.00		
	01-21-2019	Billed Medicaid Dean Care				
	02-08-2019	Managed care payment	-144.14	-144.14		
	02-08-2019	Contractual Allowance Adjustment	-360.86	-360.86		
		Visit Total:	-0.00	0.00	-0.00	
		Unpaid Balance:		0.00	-0.00	

CERNER DCN STMT1.1

Total patient payments and or co-payments applied since last statement: $0.00

*R - Description of Remarks

EXHIBIT B